

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

793-63-003271
793 STATE FILE NUMBERDO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Webster Grove	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 221 No. Rock Hill Rd.	
3. NAME OF DECEASED (Type or print) Frank H. Brown Sr.		4. DATE OF DEATH Month January Day 22 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/22/1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
13a. FATHER'S NAME Thomas Brown		14. NAME OF HUSBAND OR WIFE Olive Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No		17. INFORMANT Olive W. Brown, 221 No. Rock Hill Rd.	
18. CAUSE OF DEATH (Enter only one cause) PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile exhaustion & dehydration DUE TO (b) Paralysis muscles of deglutition DUE TO (c) Parkinsonian Syndrome		INTERVAL BETWEEN ONSET AND DEATH 7-10 days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of femur 12-20-62		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 350 X F	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Sept. 1925 to 1-23-63 and last saw her alive on 1-22-63 Death occurred at 11:55 pm m on the date stated above, and to the best of my knowledge, from the causes stated.		3	
22a. SIGNATURE (Degree or title) J. A. Sterling M.D.		22b. ADDRESS 1230 Kenmore Dr. Kirkwood 22	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-25-63	
23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. JAN 24 1963	
26. REGISTRAR'S SIGNATURE Boan Smith, M.D.			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4711 Washington
St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.